N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Facility Services
2718 Mail Service Center
Mental Health Licensure and Certification Section
Raleigh, North Carolina 27699-2718

LICENSURE APPLICATION FOR MH/DD/SAS FACILITIES

1. TYPE OF LICENSURE APPLICATION:
Renewal ☐ Change of Facility Name ☐ *Change of Capacity ☐
Change of Licensee/Ownership ☐ *Change of Location ☐ *(see application instruction sheet)
Other (specify): _____ **License Number**: MHL-_____-_____

2. FACILITY NAME: _____
(Name which the facility is advertised or presented to the public or the exact name on your current license)

3. FACILITY SITE ADDRESS: (NO P.O. BOXES) (if change of location complete & submit page 7)
Street: _____

City_____ Zip Code_____ County_____

Facility Telephone Number (_____)_____ Fax Number (_____)_____

FACILITY CORRESPONDENCE MAILING ADDRESS:

Address to: _____

Street: _____

City_____ Zip Code_____ County_____

Email address: _____

4. NAME OF FACILITY DIRECTOR: _____

5. NAME OF CONTACT PERSON: _____

Title: _____

Telephone Number: (_____)_____ Fax Number:(_____)_____

6. AUTHENTICATING SIGNATURE: This undersigned, representing the governing authority, submits information for the above named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: _____ Title: _____

Signature: _____ Date: _____

When renewing a license, submit only the completed application, fee*, fire and sanitation inspection reports. Direct all questions concerning the licensing process to the Mental Health Licensure and Certification Section Raleigh office at (919) 855-3795 FAX: (919) 715-8078 OR Asheville office at (828) 232-5084 fax: (828) 232-2433 *instituted Oct. 2003 G.S. 122G-23(h)

ALL APPLICATIONS MUST BE MAILED AND MUST HAVE AN ORIGINAL SIGNATURE.

OFFICIAL USE ONLY:

Licensure Categories:_____
Licensure Recommendation:_____
Remarks:_____
_____
DFS Consultant:_____

If change of ownership/licensee: (if no changes skip #7)

7. SIGNATURE(S) OF *OLD* LICENSEE/APPLICANT:

_____
(Full legal name of individual, partnership, corporation or other legal entity with ownership, liability, and governing authority)

AUTHENTICATING SIGNATURE(S) OF *NEW* LICENSEE: This undersigned, representing the governing authority, submits information for the above named facility and certifies the accuracy of this information in accordance with 10A NCAC 27G.

Name: _____Title: _____

Signature: _____ Date: _____

8. LEGAL IDENTITY OF OWNERSHIP/LICENSEE:
Full legal name of individual, partnership, corporation or other legal entity which owns the mental health facility business . Owner/Licensee means any person/business entity who has legal or equitable title to or a majority interest in the mental health facility. This entity is responsible for financial and contractual obligations of the business and will be recorded as the licensee on the license.

Name: _____

Address: _____

_____

Business Phone # of Applicant/Licensee: (_____)_____ Fax (___)_____

(a) Social Security Number/Federal Tax ID number of Owner/Licensee**:**_____
We ask that you voluntarily provide your social security number here and where subsequently requested in this document with the understanding that it will be used only as an identification number for internal record keeping and data processing

(b) Legal entity is: ____ For Profit ____ Not for Profit

(c) Legal entity is: ____ Proprietorship
____ Corporation ____ Limited Liability Company
____ Partnership ____ Limited Liability Partnership
____ Government Unit

(d) If the "licensee" is a corporation or partnership list the name and other requested information of the Executive Officer or General Partner.

Name: _____Social Security Number: _____

Address:_____

Telephone Number: (___)_____ Fax Number: (___)_____

Percentage interest in this facility: _____

(e) Does the above entity (partnership, corporation, etc.) own the building from which services are offered? YES___ NO___

If "NO", give the name, address, phone number of building owner:

_____
_____
_____
(_____)_____

(f) If **NO** individual holds an interest of 5% or more please indicate so by signing the statement below.

There are no owners, partners, affiliates of shareholders who hold an interest of 5% or more of the entity applying for or renewing a license:

_____ _____ _____
Signature ***Title*** ***Date***

(g) List the names and other requested information on all individuals or entities who are owners, partners, affiliates or shareholders **holding an interest of 5% or more** of the applicant entity. Attach additional pages if necessary.

Name: _____ Social Security Number: _____

Address: _____

Telephone Number: (___)_____ Fax Number: (___)_____

Percentage interest in this facility: _____

Name: _____ Social Security Number: _____

Address: _____

Telephone Number: (___)_____ Fax Number: (___)_____

Percentage interest in this facility: _____

Name: _____Social Security Number:_____

Address: _____

Telephone Number: (___)_____ Fax Number: (___)_____

Percentage interest in this facility: _____

Name: _____Social Security Number:_____

Address:_____

Telephone Number: (___)_____ Fax Number: (___)_____

Percentage interest in this facility: _____

9. EXTENSIONS IN OWNERSHIP:

North Carolina General Statute also requires information about "affiliates" of the applicant entity. "Affiliate" means any individual, partnership, or corporation which controls a mental health facility and is also directly or indirectly controlled by the applicant entity; or any individual, partnership, or corporation which controls a mental health facility and also directly or indirectly controls the applicant entity.

(a) Is the applicant entity controlled by any other organization that operates licensed mental health facility? Yes_____ No_____

(b) Does the applicant entity control any other organizations that control any other licensed mental health facilities? Yes_____ No_____

(c) If the answer to (a) or (b) above is "Yes" list the name of the other organization(s) and provide the requested information on the individuals who control 5% or more of that organization.*

Organization Name: _____ Federal Tax ID Number: _____

Address:_____

Telephone Number: (___)_____ Fax Number: (___)_____

Attach additional pages if necessary.

10. MANAGEMENT COMPANY

Is this facility being managed by the licensee? _____Yes ____No

If answered **no** above, give the following information about the management company:

Name: _____

Address:_____

Telephone Number: (___)_____ Fax Number: (___)_____

11. AREA AUTHORITY

Does this facility have a contract with one or more area mental health, development disability and substance abuse authority? _____Yes _____No

If so, please list the name(s) of area authority or authorities:

_____

_____

_____

12. ACCREDITATION: If the facility has been accredited by any nationally accrediting agency, give the name of the agency, the date the site was last inspected by the agency, and the categories for which accreditation was granted:

_____

_____

13. SERVICE CATEGORIES:

Services subject to licensure under G.S. 122C are shown in the table below and **are found in the Rules For Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services** book. All applicants must complete the following table for all services which are to be provided by the facility. If the service is not offered, leave the spaces blank. ***(***www.dhhs.state.nc.us/mhddsas/forms/***)***

If change of service category: Changing to:_____ Is now:_____ Adding: _____

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	**Check Service of License**	**Beds Assigned by Age**		
		0-17	**18 & up**	**Total Beds**
.1100 Partial hospitalizations for individuals who are acutely mentally ill.				
.1200 Psychosocial rehabilitation facilities for individuals with severe and persistent mental illness				
.1300 Residential treatment facilities for children and adolescents who are emotionally disturbed or have a mental illness (Max. of 12 clients)				
.1400 Day treatment for children and adolescents with emotional or behavioral disturbances				
.1500 Intensive residential treatment facilities for children & adolescents who are emotionally disturbed or who have a mental illness (Max. of 12 clients in each unit)				
.2100 Specialized community residential centers for individuals with developmental disabilities. (Max. of 30 clients) (CON required)				
.2200 Before/after school and summer developmental day services for children with or at risk for developmental delays, developmental disabilities, or atypical development				
.2300 Adult Developmental and vocational programs for individuals with developmental disabilities				
.2400 Developmental day services for children with or at risk for developmental delays, developmental disabilities or atypical development. (can be licensed thru DCD)				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	**Check Service of License**	**Beds Assigned by Age**		
		0-17	**18 & up**	**Total Beds**
.3100 non-hospital medical detoxification for individuals who are substance abusers (CON required)				
.3200 Social setting detoxification for substance abuse (CON required)				
.3300 Outpatient detoxification for substance abuse				
.3400 Residential treatment/rehabilitation for individuals with substance abuse disorders (CON required)				
.3500 Outpatient facilities for individuals with substance abuse disorders (Max. of 20 participants)				
.3600 Outpatient narcotic addiction treatment				
.3700 Day treatment facilities for individuals with substance abuse disorders				
.4100 Therapeutic homes for individuals with substance abuse disorders and their children (Min. 3 clients)				
.4300 A supervised therapeutic community for individuals with substance abuse disorder				

Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	Check Service of License	Beds Assigned by Age		
		0-17	18 & up	Total Beds
.5000 Facility based crisis service for individuals of all disability groups				
.5100 Community respite services for individuals of all disability groups				
.5200 Residential therapeutic (habilitative) camps for children and adolescents of all disability groups				
.5400 Day activity for individuals of all disability groups				
.5500 Sheltered workshops for individuals of all disability groups				
Rule 10A NCAC 27G Licensure Rules For Mental Health Facilities	**Check Service of License**	**Beds Assigned by Age**		
		0-17	**18 & up**	**Total Beds**
. 5600 Supervised living for individuals of all disability groups (CON required for ICF/MR facility)				
5600**A** Group homes for adults whose primary diagnosis is mental illness (Max. of 6 clients)				
5600**B** Group homes for minors whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600**C** Group homes for adults whose primary diagnosis is mental retardation or other developmental disabilities (Max. of 6 clients)				
.5600**D** Group homes for minors with substance abuse problems				
.5600**E** Half-way houses for adults with substance abuse problems				
.5600**F** Alternative family living - providing services in own private residence (Max. of 3 clients)				

14. NUMBER OF CLIENTS: (skip #13 & 14 if day program only)

Number of clients for which the facility is going to be licensed to service.

_____ Ambulatory (number that are able to evacuate without assistance)

_____ Non-Ambulatory, 1-3

_____ Non-Ambulatory, More than 3

15. NUMBER AND AGE(S) OF PEOPLE OTHER THAN CLIENTS RESIDING WITHIN THE FACILITY:

_____

_____

Are any of these non-ambulatory? Yes ☐ No ☐

16. SIGNATURE OF PERSON RESPONSIBLE FOR INFORMATION ON THIS APPLICATION:

Signature _____ Date: _____

Please complete this page if you are submitting this application for a physical change of location of facility.

PHYSICAL PLANT:

- Provide directions or map from the nearest major highway, street or intersection.
- Provide documentation that the proposed facility is approved through the local Zoning Department for the proposed use.
- Submit pictures and floor plane with dimensions of home

1. Authorities Having Jurisdiction

Local Building Official:

Department Name: _____

Address_____

City _____ County _____

Telephone ___(_____)_____

Local Fire Marshal:

Department Name _____

Address_____

City _____ County _____

Telephone ___(_____)_____

Local Sanitation:

Department Name_____ _____

Address_____

City _____ County _____

Telephone ___(_____)_____

2. Building Information:

Has the building housed a licensed facility previously? Yes ☐ No ☐

If Yes: Type of licensed facility _____

Previous License # _____ Dates of Licensure From _____ To _____

Does this building(s) contain facilities licensed for a different use other than the one an initial license is being sought for? Yes ☐ No ☐

If Yes, please clarify _____

Is the building a site constructed home or a *manufactured/mobile home? _____

(* If it is a manufactured/mobile home-contact the DFS Construction Section for licensure limitations on this type of structure.)

If it is a manufactured/mobile home, was it built after 1976? Yes ☐ No ☐